STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005004	A. BUILDING: _____ B. WING _____	02/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST MARGARET HEALTH - HAMMOND	5454 HOHMAN AVE HAMMOND, IN 46320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for one State complaint investigation. Complaint Number: IN00171295 Unsubstantiated; lack of sufficient evidence Survey date: February 29, 2016 Facility Number: 005004 Franciscan St. Margaret Health-Hammond is in compliance with 410 IAC 15-1.5-2, Infection Control and 410 IAC 15-1.5-6, Nursing services, Indiana Hospital Licensure Rules. QA: cjl 03/28/16	S 000		